CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 598

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 27, 2005

Change Request 3890

NOTE: Transmittal 595, dated June 24, 2005 is rescinded and replaced with Transmittal 598, dated June 27, 2005. The effective and implementation dates were changed to read January 1, 2006. All other information remains the same.

SUBJECT: Implementation of Carrier Guidelines for End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry (AMCC) Tests (Supplemental to Change Request 2813)

I. SUMMARY OF CHANGES: This instruction supplements Change Request (CR) 2813 (Transmittal 198, issued on June 2, 2004) by implementing carrier procedures to enforce compliance with the payment policy for End Stage Renal Disease (ESRD)-related laboratory services. CMS is implementing these new procedures in response to payment vulnerabilities identified by the Office of the Inspector General. The standard system requirements specified in CR 2813 have been implemented in multiple releases. This transmittal also makes technical corrections to the manual.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2006

IMPLEMENTATION DATE : January 1, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – ***Only One Per Row***.

R/N/D	Chapter / Section / SubSection / Title
R	8/60.1/Lab Services
R	16/40.6.1/Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs

R	16/40.6.2/Claims Processing for Separately Billable Tests for ESRD Beneficiaries

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 598	Date: June 27, 2005	Change Request 3890

NOTE: Transmittal 595, dated June 24, 2005 is rescinded and replaced with Transmittal 598, dated June 27, 2005. The effective and implementation dates were changed to read January 1, 2006. All other information remains the same.

SUBJECT: Implementation of Carrier Guidelines for End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry (AMCC) Tests (Supplemental to Change Request 2813)

NOTE: This instruction supplements Change Request (CR) 2813, "End Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests" by establishing new carrier procedures to enforce compliance with the payment policy for ESRD-related laboratory services (i.e., the ESRD 50/50 rule). The standard system requirements specified in CR 2813 have been implemented in multiple releases.

I. GENERAL INFORMATION

A. Background:

Medicare's composite rate payment to an ESRD facility or monthly capitation payment (MCP) to a physician includes reimbursement for certain routine clinical laboratory test furnished to an ESRD beneficiary. However, separate payment for such clinical laboratory tests may only be made when more than 50 percent of all Medicare-covered laboratory services furnished on a particular date of service are Automated Multi-channel Chemistry (AMCC) tests that are not included in the composite payment rate. When the 50 percent threshold is met (for a particular date of service), then all laboratory tests (composite payment rate and non-composite payment rate tests) furnished on that date are separately payable. Conversely, if the 50 percent threshold is not met (for a particular date of service) then no laboratory tests (including non-composite payment rate tests) furnished on that date of service are separately payable.

The laboratory tests subject to the rule are those tests that are included within AMCC tests and then only when furnished to an ESRD beneficiary based upon an order by a doctor rendering care in the dialysis facility or by an MCP physician at the dialysis facility for the diagnosis and treatment of the beneficiary's ESRD. (NOTE: Tests ordered by the MCP physician outside of the dialysis clinic are not subject to the ESRD 50/50 rule.)

The Office of Inspector General (OIG) has conducted several audits and has concluded that Medicare payments for ESRD laboratory-related tests are not in compliance with our payment policy. In response to the payment vulnerabilities identified by the OIG, this instruction directs the Medicare carriers to implement new guidelines to ensure that ESRD laboratory claims are processed and paid in accordance with our payment policy. The standard system changes needed to implement these new guidelines have been implemented across multiple releases, effective with the implementation of CR 2813 (Transmittal 198, issued on June 4, 2004).

B. Policy:

An allowance for AMCC tests for an ESRD beneficiary is included under the composite payment rate to the ESRD facility or capitation payment to the MCP physician. Separate payment for such tests is not made except as permitted under the payment rule specified below. The policy permits separate payment for AMCC tests for an ESRD beneficiary when more than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In that event, all of the AMCC tests (composite payment rate tests and non-composite payment rate tests) furnished on that date are separately payable. Conversely, if the threshold is not met (for a particular date of service), then no AMCC test (including non-composite payment rate tests) furnished on that date is separately payable. (NOTE: Laboratories may choose not to submit claims for ESRD-related AMCC tests to Medicare for dates of service when the threshold is not met and separate payment for the tests is not permitted.)

With respect to the application of the payment policy for AMCC tests for ESRD beneficiaries, the following apply:

1) Payment is at the lowest rate even if those automated tests were submitted as separate claims for tests performed by the same provider, for the same beneficiary, for the same date of service.

2) For a particular date of service, the laboratory identifies the AMCC tests ordered that are included in the composite rate and those that are not included. The composite payment rate is defined for Hemodialysis, Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (Attachment 1) and for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Attachment 2).

3) If 50 percent or more of the covered tests are included under the composite payment rate, then all submitted claims are included within the composite payment. In this case, no separate payment in addition to the composite payment rate is made for any of the separately billable tests.

4) If more than 50 percent of the covered tests are non-composite payment rate tests, all AMCC tests submitted for that date of service are separately payable. (A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary.)

5) All chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually. Carriers must reject claims for these tests when billed as a panel.

Three pricing modifiers discreetly identify the different payment situations for ESRD AMCC services. When billing for AMCC tests, the laboratory must identify the appropriate modifier for each test, as follows:

- CD – AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.

- CE – AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.

- CF – AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

ESRD clinical laboratory tests identified with modifiers "CD", "CE" or "CF" may not be billed as organ or disease panels. Upon the effective date of this business requirement, all ESRD clinical laboratory test must be billed individually.

When billing Medicare for ESRD-related AMCC tests, laboratories must:

a. Identify which tests, if any, are not included within the ESRD facility composite rate payment.

b. Identify tests ordered for chronic dialysis for ESRD as follows:

1) Modifier CD: AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.

2) Modifier CE: AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.

3) Modifier CF: AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

c. Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel. (NOTE: Separate payment for ESRD-related AMCC tests may be made only when more than 50 percent of all Medicare-covered laboratory services furnished on a particular date of services are AMCC tests that are not included in the composite payment rate. For dates of service when this threshold is not met, and separate payment may not be made, laboratories may choose not to submit claims to Medicare for these tests.)

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3890.1	Effective for claims with dates of service on or after January 1, 2006, carriers shall return as unprocessable line items that contain a procedure (identified in attachments 1 and 2) reported with modifier "CE" and modifier "91" when there is no line item on the claim or a claim in history or in cycle for that date of service with modifier "CE" only.			X			X			
3890.2	Effective for claims with dates of service on or after January 1, 2006, carriers shall return as unprocessable line items that contain a procedure (identified in attachments 1 and 2) reported with modifier "CF" and modifier "91" when there is no line item on the claim or a claim in history or in cycle for that date of service with modifier "CF" only.			X						
3890.3	When returning a claim as unprocessable, as outlined in business requirements 3890.1 and 3890.2, carriers shall use remittance advice remark code M78 and reason code 125.			X						
3890.4	Effective for claims with dates of service on or after January 1, 2006, carriers shall return as unprocessable laboratory panel codes billed with the "CD", "CE", and "CF" modifiers, using remittance advice remark code N56 and reason code 4.			X						
3890.5	Effective for claims with dates of service on or after January 1, 2006, carriers shall return as unprocessable line items submitted with a CD modifier and a "91" modifier on the same line item, using remittance advice remark code M78 and reason code 125.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3890.6	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into your outreach activities, as appropriate. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 1, 2006 **Pre-Implementation Contact(s):** Susan Webster, (410) 786-3384. **Post-Implementation Contact(s):** Contact the appropriate regional office.	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs

(Rev. 598, Issued: 06-27-05, Effective: 01-01-06; Implementation: 01-01-06)

A-03-033

Medicare will apply the following rules to Automated Multi-Channel Chemistry (AMCC) tests for ESRD beneficiaries:

- Payment is at the lowest rate for tests performed by the same provider, for the same beneficiary, for the same date of service.
- The *laboratory* must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that *d*ate of *s*ervice for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.
- For carrier processed claims, all chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.

(See §100.6 for details regarding pricing modifiers.)

Implementation of this Policy:

When billing Medicare for ESRD-related AMCC tests, laboratories must:

a. Identify which tests, if any, are not included within the ESRD facility composite rate payment.

b. Identify which tests have been ordered for chronic dialysis for ESRD as follows:

1) Modifier CD: AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.

2) Modifier CE: AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.

3) Modifier CF: AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

c. Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel.

(NOTE: Separate payment for ESRD-related AMCC tests may be made only when more than 50 percent of all Medicare-covered laboratory services furnished on a particular date of service are AMCC tests that are not included in the composite payment rate. For dates of service when this threshold is not met, and separate payment may not be made, laboratories may choose not to submit claims to Medicare for these tests.)

The shared system must calculate the number of AMCC tests provided for any given date of service. Sum all AMCC tests with a CD modifier and divide the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service.

If the result of the calculation for a date of service is 50 percent or greater, do not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, pay for all of the tests.

For FI processed claims, all tests for a date of service must be billed on the monthly ESRD bill. Providers that submit claims to a FI, must send in an adjustment if they identify additional tests that have not been billed.

Carrier standard systems shall adjust the previous claim when the incoming claim for a date of service is compared to a claim on history and the action is to adjust payment. Carrier standard systems shall spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

The organ and disease oriented panels (80048, 80051, 80053, and 80076) are subject to the 50 percent rule. However, clinical diagnostic laboratories shall not bill these services as panels, they must be billed individually. Laboratory tests that are not covered under the composite rate and that are furnished to CAPD ESRD patients dialyzing at home are billed in the same way as any other test furnished home patients.

FI Business Requirements for ESRD Reimbursement of AMCC Tests:

Requirement Number	Requirements	Responsibility
1.1	The FI shared system must RTP a claim for AMCC tests when a claim for that date of service has already been submitted.	Shared system
1.2	Based upon the presence of the CD, CE and CF payment modifiers, identify the AMCC tests ordered that are included and not included in the composite rate payment.	Shared system
1.3	Based upon the determination of requirement 1.2, if 50 percent or more of the covered tests are included under the composite rate, no separate payment is made.	Shared system
1.4	Based upon the determination of requirement 1.2, if less than 50 percent are covered tests included under the composite rate, all AMCC tests for that date of service are payable.	Shared system
1.5	Reject line items that contain a procedure (identified in exhibit 1 and 2) with a modifier CE and a modifier 91 and no line item on the claim with modifier CE and no modifier 91.	Shared system
1.6	Reject line items that contain a procedure (identified in exhibits 1 and 2) with a modifier CF and a modifier 91 and no line item on the claim with modifier CF and no modifier 91.	Shared system
1.7	FI must return any claims for additional tests for any date of service within the billing period when the provider has already submitted a claim. Instruct the provider to adjust the first claim.	FI or Shared system
1.8	Do not apply the 50/50 rule to line items for one of the chemistries in exhibits 1 or 2 that contain modifiers CE or CF and modifier 91 on the line item.	Shared system

Carrier Business Requirements for ESRD Reimbursement of AMCC Tests:

Requirement Number	Requirements	Responsibility
1	The standard systems shall calculate payment at the lowest rate for these automated tests even if reported on separate claims for services performed by the same provider, for the same beneficiary, for the same date of service.	Standard Systems
2	Standard Systems shall identify the AMCC tests ordered that are included and are not included in the composite rate payment based upon the presence of the "CD," "CE" and "CF" modifiers.	Standard Systems
3	Based upon the determination of requirement 2 if 50 percent or more of the covered services are included under the composite rate payment, Standard Systems shall indicate that no separate payment is provided for the services submitted for that date of service.	Standard Systems
4	Based upon the determination of requirement 2 if less than 50 percent are covered services included under the composite rate, Standard Systems shall indicate that all AMCC tests for that date of service are payable under the 50/50 rule.	Standard Systems
5	Standard Systems/local carriers shall return as unprocessable line items that contain a procedure reported with modifier "CE" and modifier 91 *when there is* no line item on the claim or a claim in history or in cycle for that date of service with modifier "CE" only.	Standard Systems/Carriers
6	Standard Systems/local carriers shall return as unprocessable line items that contain a procedure reported with modifier "CF" and modifier 91 *when there is* no line item on the claim or a claim in history or in cycle for that date of service with modifier "CF" only.	Carriers

7	Standard Systems shall not apply the 50/50 rule to line items for one of the chemistries that contain modifiers “CE” or “CF” and modifier 91 on the line item.	Standard Systems
8	Standard Systems shall adjust the previous claim when the incoming claim is compared to the claim on history and the action is to deny the previous claim. Spread the payment amount over each line item on both claims (the adjusted claim and the incoming claim).	Standard Systems
9	Standard Systems shall spread the adjustment across the incoming claim unless the adjusted amount would exceed the submitted amount of the services on the claim.	Standard System
10	Local carriers shall return as unprocessable claims submitted as outlined in business rules 5 and 6. When *returning line items as unprocessable,* based upon the requirements of 5 and 6, local carriers shall use remittance advice remark code M78 *and* reason code 125.	Carriers
11	Local carriers shall return a*s* unprocessable lab panel codes billed with the “CD”, “CE”, and “CF” modifiers, *using* remittance advice remark code N56 *and* reason code 4.	Carriers
12	Local carriers shall return as unprocessable line items submitted with a “CD” modifier and “91” modifier on the same line item. When returning a*s* unprocessable line items that contain a “CD” modifier and a “91” modifier, local carriers shall use remittance advice remark code M78 *and* reason code 125.	Carriers

Examples of the Application of the 50/50 Rule

The following examples are to illustrate how claims should be paid. The percentages in the action section represent the number of composite rate tests over the total tests. If this percentage is 50 percent or greater, no payment should be made for the claim.

Example 1:

Provider Name: Jones Hospital

DOS 2/1/02

Claim/Services 82040 Mod CD

82310 Mod CD

82374 Mod CD

82435 Mod CD

82947 Mod CF

84295 Mod CF

82040 Mod CD (Returned as duplicate)

84075 Mod CE

82310 Mod CE

84155 Mod CE

ACTION: 9 services total, 2 non-composite rate tests, 3 composite rate tests beyond the frequency, 4 composite rate tests; 4/9 = 44.4%<50% pay at ATP 09

Example 2:

Provider Name: Bon Secours Renal Facility

DOS 2/15/02

Claim/Services 82040 Mod CE and Mod 91

84450 Mod CE

82310 Mod CE

82247 Mod CF

82465 No modifier present

82565 Mod CE

84550 Mod CF

82040 Mod CD

84075 Mod CE

82435 Mod CE

82550 Mod CF

82947 Mod CF

82977 Mod CF

ACTION: 11 services total, 6 non-composite rate tests, 4 composite rate tests beyond the frequency, 1 composite rate test; 1/11 = .09.4%<50% pay at ATP 12

Example 3:

Provider Name: Sinai Hospital Renal Facility

DOS 4/02/02

Claim/Services 82565 Mod CD

83615 Mod CD

82247 Mod CF

82248 Mod CF

82040 Mod CD

84450 Mod CD

82565 Mod CE

84550 Mod CF

82248 Mod CF (Duplicate

ACTION: 8 services total, 4 composite rate tests; 4/8 = 50%, therefore no payment is made

Example 4:

Provider Name: Dr. Andrew Ross

DOS 6/01/02

Claim/Services 84460 Mod CF

82247 Mod CF

82248 Mod CF

82040 Mod CD

84075 Mod CD

84450 Mod CD

ACTION: 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50%, therefore no payment.

Example 5: (Carrier Processing Example Only)

Payment for first claim, second creates a no payment for either claim

Provider Name: Dr. Andrew Ross

DOS 6/01/02

84460 Mod CF

82247 Mod CF

82248 Mod CF

ACTION: 3 services total, 3 non-composite rate tests, 0 composite rate tests beyond the frequency, and 0 composite rate tests tests, 0/3 = 0%, thereforeATP 03

Second Claim: No payment.

Provider Name: Dr. Andrew Ross

DOS 6/01/02

82040 Mod CD

84075 Mod CD

84450 Mod CD

ACTION: An additional 3 services are billed, 0 non-composite rate tests, 8 composite rate test beyond the frequency, 3 composite rate tests. For both claims there are 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50% ≥ 50%, therefore no payment. An overpayment should be recovered for the ATP 03 payment

40.6.2 - Claims Processing for Separately Billable Tests for ESRD Beneficiaries

(Rev. 598, Issued: 06-27-05, Effective: 01-01-06; Implementation: 01-01-06)

Clinical laboratory tests can be performed individually or in predetermined groups on automated profile equipment. If a test profile is performed see §40.6.1. If a clinical laboratory test is performed individually, see §40.6.2.1 or §40.6.2.2 depending upon whether the patient is treated in a hospital-based or independent dialysis facility**.** *However the tests are performed in the laboratory setting, the services must be billed individually, and must not be billed in a group as an organ or disease panel.*

60.1 - Lab Services

(Rev. 598, Issued: 06-27-05, Effective: 01-01-06; Implementation: 01-01-06)

A3-3644.1, PRM-1-2711.1, B3-4270.2, RDF-322, A3-3167.3

See the Medicare Benefit Policy Manual, Chapter 11, for a description of lab services included in the composite rate.

Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with CLIA may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. Independent dialysis facilities billing for separately billable laboratory tests that they perform must submit claims to the FI. Independent laboratories must bill the carrier.

Hospital-based laboratories providing separately billable laboratory service*s* to hospital dialysis patients of the hospital's dialysis facility bill separately and are paid in accordance with the outpatient lab provisions. However, where the hospital lab does tests for an independent dialysis facility or for another hospital's facility, the non-patient billing provisions apply.

Clinical laboratory tests *are* performed individually. Automated profiles and application of the "50 percent rule" can be found in Chapter 16 of this manual.

A specimen collection fee determined by CMS (as of this writing, up to $3.00) will be allowed for ESRD Method II billing only in the following circumstances:

- Drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with a syringe or vacutainer to draw the specimen).
- Collecting a urine sample by catheterization.

Laboratory tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (as specifically listed below) are usually performed for dialysis patients and are routinely covered at the frequency specified in the absence of indications to the contrary, i.e., no documentation of medical necessity is required other than knowledge of the patient's status as an ESRD beneficiary. When any of these tests is performed at a frequency greater than that specified, the additional tests are separately billable and are covered only if they are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim. Such information must be furnished using the ICD-9-CM coding system.

Per Treatment

All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments

Weekly

Prothrombin time for patients on anticoagulant therapy

Serum Creatinine

Weekly or Thirteen Per Quarter

BUN

Monthly

Serum Calcium	Serum Bicarbonate	Alkaline Phosphatase
Serum Potassium	Serum Phosphorous	AST, SGOT
Serum Chloride	Total Protein	LDH
CBC	Serum Albumin	

Automated Battery of Tests - If an automated battery of tests, such as the SMA-12, is performed and contains most of the tests listed in one of the weekly or monthly categories, it is not necessary to separately identify any tests in the battery that are not listed.

Guidelines for Separately Billable Tests for Hemodialysis, IPD, CCPD, and Hemofiltration

Serum Aluminum - one every 3 months

Serum Ferritin - one every 3 months

ESRD COMPOSITE RATE TESTS
CAPD
Chemistry Tests

	Chemistry	CPT Code	Monthly	Weekly	13 X quarter
1	Albumin	82040	X		
2	Alkaline phosphatase	84075	X		
3	ALT (SGPT)	84460			
4	AST (SGOT)	84450	X		
5	Bilirubin, total	82247			
6	Bilirubin, direct	82248			
7	Calcium	82310	X		
8	Chloride	82435			
9	Cholesterol	82465			
10	CK, CPK	82550			
11	CO2 (bicarbonate)	82374	X		
12	Creatinine	82565	X		
13	GGT	82977			
14	Glucose	82947			
15	LDH	83615	X		
16	Phosphorus	84100	X		
17	Potassium	84132	X		
18	Protein, total	84155	X		
19	Sodium	84295	X		
20	Triglycerides	84478			
21	Urea nitrogen (BUN)	84520	X		
22	Uric Acid	84550			

non-composite rate test

composite rate test

ESRD COMPOSITE RATE TESTS
NON-CAPD
Chemistry Tests

	Chemistry	CPT Code	Monthly	Weekly	13 X quarter
1	Albumin	82040	X		
2	Alkaline phosphatase	84075	X		
3	ALT (SGPT)	84460			
4	AST (SGOT)	84450	X		
5	Bilirubin, total	82247			
6	Bilirubin, direct	82248			
7	Calcium	82310	X		
8	Chloride	82435	X		
9	Cholesterol	82465			
10	CK, CPK	82550			
11	CO2 (bicarbonate)	82374	X		
12	Creatinine	82565		X	
13	GGT	82977			
14	Glucose	82947			
15	LDH	83615	X		
16	Phosphorus	84100	X		
17	Potassium	84132	X		
18	Protein, total	84155	X		
19	Sodium	84295			
20	Triglycerides	84478			
21	Urea nitrogen (BUN)	84520			X
22	Uric Acid	84550			

= non-composite rate test

= composite rate test